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CBO STUDY ON INCLUDING CAPITAL EXPENSES IN THE PPS

In 1983, the Congress changed Medicare's system of paying for inpatient hospital services from a retrospective, cost-based reimbursement system to a prospective payment system (PPS). Payments for capital-related expenses, however, were not included in the PPS, and they continued to be paid on a cost basis. A study by the Congressional Budget Office, conducted at the request of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, finds that incorporating capital costs in the PPS would help alleviate two problems of the current, cost-based system: inefficiency and lack of budget control. The principal disadvantage of including capital costs in the PPS, however, is that some hospitals might not be able to adjust to a system in which payments for capital would not rise and fall with capital costs.

Immediately including capital in the PPS would cause windfall losses for some hospitals and windfall gains for others. For example, a simulation of payments under an illustrative payment system indicated that 60 percent of all hospitals would have received higher Medicare payments for capital in 1984 than under cost-based reimbursement, assuming their behavior was unchanged. On the other hand, almost 30 percent of hospitals would have received at least 20 percent less compared with cost-based reimbursement. These changes would have been modest, however, compared with those that would have resulted if the PPS for operating costs had not provided a transition period. Furthermore, since hospitals would have incentives to be more economical in their use of capital under the PPS, the actual reductions in payments for capital expenses would be smaller than estimated and the gains would be larger.

Transition policies would provide relief for at least some of the hospitals that would receive less if capital payments were included in the PPS immediately, but would also reduce the incentives for more economic behavior. The three transition options analyzed in the CBO report are: blend prospective amounts with hospital-specific costs; pay more for exceptionally high costs (or "outliers"); and "grandfather" existing capital--that is, continue to use cost-based reimbursement for capital in place before a specific date. The advantages and disadvantages of each option are examined at length in the study.

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